2020 Health and Life Insurance
RETIREE – Election Form

PRIMARY INFORMATION – please PRINT

Use this form for initial insurance enrollment or for an eligible qualifying event. **Additional paperwork may be required** (see the Required Documentation and Dependent Eligibility document) and return to the Health Insurance Team by the applicable deadline.

SSN: _____

Name: _____

Street Address: _____

City, State, ZIP Code: _____

Telephone Home #: (_____) _____ – _____ Cell #: (_____) _____ – _____

Email Address: _____

*Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.*

Medical (choose one)

Medicare Part B is required when eligible.

- ❑ No Medical
- ❑ Kaiser HMO (includes Kaiser Rx)
- ❑ United HealthCare HMO
- ❑ CareFirst POS High Option
- ❑ CareFirst POS Standard Option

Prescription / Rx (choose one)

For Kaiser and Indemnity plan participants, no Rx election is needed as Rx coverage is included in your plan

- ❑ No Prescription Coverage
- ❑ High Option $5/$10
- ❑ Standard Option $10/$20/$35

Dental (choose one)

- ❑ No Dental Coverage
- ❑ Dental PPO (traditional dental plan)

Optional Life (choose one)

- ❑ Cancel Optional Life Coverage
- ❑ Keep Current Optional Life Coverage

Vision Plan (choose one)

- ❑ No Vision Coverage
- ❑ Discount Vision

Dependent Life (choose one)

- ❑ Cancel Dependent Life Coverage
- ❑ Keep Current Dependent Life Coverage

Over ↺

DEPENDENT COVERAGE – please PRINT

To change dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.). Note that you must elect the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form (e.g., your dependent may not have the vision plan unless you do). Also, the number of dependents you cover under each plan will determine your coverage level (Self, Self+1 or Family) and your cost for each plan.

❑ **Add Eligible Dependent(s)** ❑ **Keep Same Dependent Coverage**

SOCIAL SECURITY *(Required)*	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP	INSURANCE ELECTIONS
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision

❑ **Delete / Disenroll Dependent(s)**

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision

SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Plan. I authorize the County to make a deduction from my ERS or LTD2 benefit for my insurance elections. If I pay directly for insurance, I will promptly pay the cost or benefits will terminate. I understand that the County may adjust my elections. I authorize the release of enrollment information to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible persons, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Plan, but it is the County's position that there is no implied contract between members and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Plan, subject to any applicable County's collective bargaining agreements. The County may also amend the Plan, prospectively or retroactively to comply with applicable law.

⇨ **Signature:** _____ **Date:** _____

Mail to: OHR Health Insurance Team, 101 Monroe St., 7th Floor, Rockville, MD 20850
or fax: 240-777-5131 (include fax/mail cover sheet)

Reminder: When you receive your Medicare card, be sure to send us a copy via fax or to the address above.